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THE TEN Ps MARKETING FRAMEWORK for HEALTHCARE AT LOW COST

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ABSTRACT

Frugal Innovation in healthcare is the key to inclusive growth and development, especially for a developing country like India. It has become a strategic option not just for aspiring entrepreneurs, social enterprises or government agencies but also for MNC's. The swelling population puts the onus of healthcare on the public sector; however, the contribution has been static where the 12th Five Year Plan envisages public funding on core health at 1.87 percent of GDP. In order to reach such a vast market, sound planning and implementation of marketing will have to be employed to make the opportunity a win-win model for both the public and private investors. The low cost solutions which meet quality standards, has endeared the offering to multiple market segments within India and to global markets. This widening market base has led to volumes that has driven down the costs for patients and opened the options for differential pricing for the entrepreneurs. The lead potential of India has resulted in reverse innovation and had given India a vantage point in global healthcare branding and marketing. The positive outcome on health tourism has benefitted the Indian economy.

The paper studies twelve cases of successful low cost health care products and services and has identified the 10 Ps framework that commonly thread the underlying low-cost healthcare delivery process.

KEYWORDS: healthcare, low-cost, innovations, entrepreneurs, marketing.

INTRODUCTION

India's public health care system is patchy, with underfunded and overcrowded hospitals and clinics, and inadequate rural coverage. Reduced funding by the Indian Government has been attributed to historic failures on the part of the Ministry of Health and Family Welfare (MHFW) to spend its allocated budget fully. This is despite increasing demand, due, in part, to growing incidence of age- and lifestyle-related chronic diseases resulting from urbanization, sedentary lifestyles, changing diets, rising obesity levels, and widespread availability of tobacco products. India's health care sector witnesses close to 50 percent spend on in-patient beds for lifestyle diseases, especially in urban and semi-urban pockets. In addition, India has one the world's highest numbers of diabetes sufferers, at more than 65 million individuals. This trend has resulted in the mushrooming of super specialty hospitals to combat lifestyle diseases.

Indian healthcare delivery system is categorized into two major components - public and private. The Government, i.e. public healthcare system comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of primary healthcare centres (PHCs) in rural areas. The private sector provides majority of secondary, tertiary and quaternary care institutions with a major concentration in metros, tier I and tier II cities.

The Ten P's marketing mix for health care innovations designed for the poor and marginalised in India offers a framework for entrepreneurs and marketers to launch their products and service using the insights gleaned from pioneering firms who perfected the system through trial and error. The framework offers a simple model to test the offering for the market at multiple levels. The attempt to answer this framework will enable entrepreneurs launch their frugal offering without long periods of iteration to fine tune their methods and approach to succeed in the very volatile and sensitive healthcare market

LITERATURE REVIEW

According to Clayton M. Christensen (2002), disruption in well established industries has occurred on account of seemingly non threatening start-ups. The entrepreneur identifies the crude material market they can serve in volume and launch their nascent offerings to cater to the low demanding, price sensitive market. The market welcomes the offering while the value of continuing in the market is unprofitable to the large, established players who move upwards to more sophisticated offerings at higher value. This movement continues till the new entrants drive out the veterans and occupy the lead positions. Investment, reputation, market position, pricing, positioning, targeting and value offering of the market giants become the limitations and barriers to stay adaptable and nimble in innovating for the changing scenario. India is such a market where the crude and coarse find place owing to the frugality of the Indian customer. The need to constantly identify low cost models is ingrained in the culture. Health care solutions have begun to emerge from India as there are constraints and limitations around which the best solutions have to evolve. This has resulted in significant breakthroughs in surgeries, treatment of diseases and lowering of mortality rates. These business models will disrupt the existing model for the world as they shape around the constraints of absence of adequate infrastructure, poverty, illiteracy, unemployment, health apathy and low government budget,.

C.K. Prahalad and R.A. Mashelkar (2010) present three types of Gandhian Innovation: (1)Disrupting business models; (2) Modifying organizational capabilities; (3) Creating or sourcing new capabilities. The entrepreneurs in India are forced to seek capital efficiency to keep the cost low. The consumer seeks value for money in every penny spent and this forces change in price-performance equation. The measures put forth by Prahalad and Hart (2002) to address the challenge to combine low cost, good quality, sustainability and profitability have been counter argued and debated but the pioneers in healthcare are going beyond government schemes and have made the principles of success in the BoP segment a reality.

In a departure in approach to the popular argument in favor of innovating around the poor and tapping riches from the vast majority at the bottom of the pyramid, Michael Porter (2006) argues on the importance of value based health care delivery. A complete restructuring of the existing model will enable the creation of value based models which will break away from the incremental improvement model. In his article with Thomas H. Lee, MD (2013), Michael Porter negates the approach to cost reduction, increasing volumes to gain profit, access to poor, and drives the need to align healthcare goals to value for the patient which is determined with health outcomes relative to the cost incurred in offering the desired outcome. The constant drive should be to ensure the value to the patient without incurring additional cost or by reworking the costing to lower the cost burden, but doing so without compromising the quality of care delivered. The emphasis on health outcomes and thereby reimbursement is paving the way for the payment modes. This will result in multiple models of payment and pressure to improve outcomes to expand the market share. The Indian system of payment is mainly out-of-pocket for the common man and this puts severe pressure on his ability to pay for healthcare. The frugal healthcare providers will seek special pricing systems to ensure access to healthcare for the poor on par with those who can pay while exempting the poor from paying.

McKinsey Report (2010) has outlined strategies to market low cost healthcare solutions successfully. One strategy is to remodel the delivery process. It moves the care provider closer to the patient by identifying community and family members, standardizing the procedures for accurate diagnosis, equipping the unsophisticated community members with products and instruments thereby opening up opportunities for earning and enterprise.

Utilizing the ubiquitous mobile networks and other infrastructure helps organizations to improve access, standardize procedures and ensure efficiency. The power and reach of internet and mobile technology can be used to offer timely advice, prevent overcrowding at the clinics, offer advice for preventive care, send reminders for follow-up checks, referrals and access to patient networks. Given the shortage of medical practitioners, empowering and training common

people to handle standard procedures and tests leaves the doctors and surgeons to attend to more patients than if they were to handle the tasks themselves. This model of efficiency has emerged as a popular mode of operation and considerably reduces the cost for the patient.

Standardization has proved to be quintessential to ensure swift, even and quality service to customers. Whether it is fast food giants or healthcare providers, recording and standardizing routine steps and procedures renders the action to train those who are not experts. The vast pool of unemployed youth, housewives and illiterate from the population can now be trained and developed to work on standard procedures thereby reducing burden on the experts and ensuring treatment for more patients. This also reduces the cost of treatment for the patients, gainfully employs the manpower available, reduces administrative and routine burden on the experts thereby freeing them to address more cases and build competencies and skills over time. Over the course of time, the doctor and nurses are able to address larger sections of the population, reducing time and cost and increasing the quality of health outcome for the patients because of the expertise gained.

The common reason why health organizations are unwilling or unable to reduce the cost for the patients is on account of the heavy capital invested in acquiring, operating and training the staff to operate the expensive machines and tools. The need to recover the cost and bill profits is translated into costs for the patient, this further burdens the middle class and prevents the poor from seeking professional help. Many enterprising organizations such as Health Management Research Institute (HMRI), Medical Home, MinuteClinics, Pesinet have modeled their reach by leveraging the reach of mobile networks, Internet access and using small space in retail outlets profitably and effectively.

The innovations and procedures that become commercially viable and popular, offer the entrepreneurs opportunities to capitalize on the large customer base, goodwill and reach. They can drive compelling new initiatives, offer new products and services, forge liaisons and enter into joint ventures and negotiate deals to lower cost

The sheer size and reach of the market offers the entrepreneurs multifaceted success, expansion and growth opportunities.

The three, A's: Affordability, Access, and Availability according to Prahalad (2002) is the guide to ensure that the solutions address these concerns. Affordability is in ensuring that the pricing per unit is within the purchasing power of the poor. Access is in ensuring that the product or service is within the reach of the poor. Availability is in ensuring that the poor are not forced to defer consumption as they live on a day to day basis and rarely hoard the goods The package size and prize should allow them the avail of the product at any given time.

In response to these challenges, Govindrajan and Ramamurti (2013) offered the model to reach the poor in healthcare based on the successful case studies.

Hub and Spoke method helps the hospital to branch out to distant towns and villages while remaining the central source of operation and the spokes function to support and assist patients apart from channeling them into the central system for specialized diagnosis and treatments.

The High volumes that comes from maintaining a lean model of operation and treating high number of patients at a given time reduces the cost per individual. This makes the service or product affordable.

OBJECTIVES

- To study and analyse the business models of successful ventures, delivering low cost healthcare
- To identify the key challenges faced by entrepreneurs in offering low cost health care to the poor and marginalised sections of India
- To identify the key growth drivers to leverage in designing the healthcare delivery model for efficiency and effectiveness
- To design and develop a marketing framework for low cost health care innovations to enable entrepreneurial success

RESEARCH AND STUDY DESIGN

The objective of this research is to understand how low cost healthcare providers have altered the business model to cater to the poor in India. The empirical research uses the case study research methodology. The goal was to identify how the organizations modelled their systems to deliver low cost healthcare to the poor of the country. The resulting model of delivery is shaped from the lessons drawn from the steps, measures and innovations made by entrepreneurs driven by concern for the marginalized without compromising on quality. The challenge in offering low cost, quality solutions to the poor is impossible unless there is a paradigm shift in designing the business model.

Case studies are widely used in organisational research and social sciences. According to Yin (2003a, p2), "the distinctive need for case studies arise out of the desire to understand complex social phenomena" because "the case study method allows investigators to retain the holistic and meaningful characteristics of real life events," such as organisational or managerial processes. Case study approach is best suited to study a contemporary phenomenon within the real life context so that answers to 'how' and 'why' can be answered. Case study approach was best suited to do an in-depth study of the dynamics which are often lost in quantitative data analysis. The detailed understanding of reality is critical in analysis of the context and processes which gives insight into the issues and theory building. The role of theory is analytic generalization as opposed to statistical generalisation ((Kohlbacher, 2006)). Multiple cases allow for discovering patterns and procedures which are common among them and unique to the system at large. The findings offer empirical evidence to sharpen the theory. As the objective was to understand and verify the theory and not testing, the use of case studies was best suited for the research.

Case study selection was based on the organizations that have been hailed as disruptive in their approach by media, business reports and academic journals.
The research methodology involved iterative case analysis process. The materials for case study analysis was taken from many sources such as the company website, awards and recognitions reports, interviews of pioneers, media reports, research articles, published books. Once a case was scrutinized for its innovative solution for the poor, the published materials, both in print and online were studied to identify commonalities, discrepancies and new insights. Cross referencing helped establish the authenticity of the facts and piece together the facts to extract the learning. Finally the findings were compiled and structured to build a simple theory which can work to help the new entrants wanting to serve the BoP segment with low cost healthcare solutions.

INDIAN HEALTHCARE SCENARIO

1. Lowest Government Spending

- India's public healthcare expenditure is the least and has remained at 1.08 per cent of GDP through 2009 to 2013, compared to 5 per cent in China and 8.3 per cent in the United States. Global evidence on health spending shows that unless a country spends at least 5-6% of its GDP on health, basic healthcare needs are seldom met. The total public expenditure share between the centre and state (33:67) has been declining creating uneven access to health within India. The burden on states has increased to 70 percent.
- Over 80 percent of heath expenditure in India is borne by private sector as against the developed countries where 80 percent is borne by the exchequer.

2. Urban - Rural Penetration Disparity

- Nearly 72% of the country's population lives in rural areas. The unequal geographic distribution of doctors and hospitals makes it difficult for low-income families to access quality medical facilities.
- Eighty percent of doctors, 75 percent of dispensaries, and 60 percent of hospitals are situated in urban areas – making quality health care virtually inaccessible to people who live in remote areas.

3. Infrastructure Gaps

- Subcenters (Scs)- 1, 53,655; Primary Health Centres (PHCs)- 25,308; Community Health Centres (CHCs)- 5,396; Sub-divisional Hospitals (SDHs)- 1022; Districts Hospitals (DH)- 763
- There is a shortfall of 33145 SCs (20%), 6556 PHCs (22%) and 2316 CHCs (32%) across the country as per the Rural Health Statistics (Ministry of Health and Family Welfare, 2016).

4. Out-of-pocket (OOP) expenditure is the share of expenses that patients pay to the healthcare provider, without a third party insurance or government-subsidised treatment.

- Despite liberalization of the insurance sector, only around 21.6 crore people - less than one-fifth of India's population - are covered under health insurance. Even among those who have some form of coverage, 67% are covered by public insurance companies (CBIH, 2015).
- The high Out-of-Pocket (OOP) medical expenditure at 80 percent has 60 percent of it spent on medicines both in Rural and Urban India
- According to the Ministry of Health and Family Welfare, 2015 report, the share of out-of-pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas, in 2011-12.
- OOP increases with the cost of medicines, followed by that of hospitalisation accounting for the largest share of the household expenditure.

5. Burden of Rising Population

- With a population of 1.21 billion, India is the second most populous country in the world, next only to China. India's population between 2001 and 2011 has increased by 181 million people and is projected to have a population of

1.44 billion by 2025 according to the National Health Profile report (CBIH, 2015).

6. Manpower shortage

- Every government hospital serves an estimated 61,000 people in India, with one bed for every 1833 people (CBIH, 2015). In undivided Andhra Pradesh, every government hospital serves over 3 lakh patients while in Bihar, there is only one bed for every 8800 people.
- Every government allopathic doctor serves a population of over 11,000 people, with Bihar and Maharashtra having the worst ratios.
- India now has cumulatively 9.4 lakh allopathic doctors, 1.54 lakh dental surgeons, and 7.37 lakh AYUSH doctors of who more than half are Ayurvedic doctors. India's 400 medical colleges admit an estimated 47,000 students annually.
- There is an 83 percent shortage of specialist medical professionals in community health centres (CHCs), according to the Rural Health Statistics-2015, released by the Ministry of Health and Family Welfare.
- Despite government investments, India added only 2.07 doctors between 2007 and 2015 (NHP, 2015).
- The doctor patient ratio in rural areas of India is 1:20,000, while the urban ratio is 1:2,000 against the statutory 1:250 ratio from WHO for which India requires 6,00,000 doctors. (PWC, 2012) Even today, 70 percent of primary healthcare is provided by unqualified practitioners.

7. Triple Burden of Diseases

1. Unfinished agenda of communicable diseases
2. Emerging non communicable diseases related to life styles
3. Emerging infectious diseases.

8. Poor health awareness

- Lack of education and public health awareness in rural India
- Misguided and inadequate knowledge of personal health care, nutrition, healthy habits, vaccination, hygiene, and illness prevention

9. Language Barriers

- More than 22 languages is part of India and English is the predominant language used in Medical studies
- With rural citizens migrating to different states, the ability to convey health issues is challenging
- It causes problems in health outcome, comprehension, adherence, quality of care delivered and satisfaction

10. Impact on Employment and Income

- The high cost of healthcare prevents the poor from accessing it, leading to perennial health problems. The prolonged neglect causes loss in productivity, efficiency and earning.
- Wage loss means financial setback to the family, lifestyle changes and discontinuation of education to make a living.
- Nearly 39 million people fall below the poverty line each year due to health-related expenditures.

Results:

From the in-depth analysis of the cases, the 10 P's of marketing frugal healthcare innovations were derived:

The Ten Ps Framework	Description
1. Practical Product	• Designed for rural conditions and poor man's psychographic profile. • rugged, portable, operates on alternative energy source, simple design, ease in handling and comprehension, reusable • Synergy using domain knowledge of engineering, Allopathy and AYUSH medicine • Lean manufacturing and Total Quality Management for continuous improvement • Empathy and health outcome at the core of value offering.
2. Paltry Pricing	Target pricing - 1 per cent of the nearest available quality option Differential pricing where rich patients subsidise poor patients EMI options, Reduce pack size for affordability Reduce fixed cost by increasing production/ doctor's efficiency and negotiating on bulk orders; rent or lease to other providers, pay per use agreements.
3. Proximity to Patients	Hub and spoke method of distribution, health camps, community outreach programs, local check-up centres, remote diagnosis,
4. Parsimonious Promotion	Leverage referral groups and community networks for speed and conversion, build trust and credibility through direct interaction, direct sales
5. People Power	Train and develop untapped idle manpower, women and family technicians for task shifting Build expertise of non-physicians in using logical algorithm or advanced software system to comprehend emergency cases Develop accreditation test for employment; immaterial of formal education.
6. Packed Process	An assembly line model for maximum case handling by limited experts Build work flow efficiency Encourage local manufacturing, borrow and integrate materials from other industries to reduce cost, increase effectiveness and improve outcome
7. Penetrating Presence	Leverage growth and penetration of digital media to share reports, use local language in digital health records, teleconferences, messages/videos on health awareness, ensure medical compliance and first aid remedies among others.
8. Public-Private Partnerships	Strengthen market position through partnerships in government initiatives and plans, Public funding, NGO's, non competing corporate houses, community systems; government micro insurance plans
9. Pioneer's Passion	Ongoing, unabated commitment to the pioneer's values to serve the poor throughout the organisation, a code of service unchanged by success or the passage of time
10. Pan International	Share the perfected product and system with international markets, operate international training and consulting unit

DISCUSSION:

The need for frugal healthcare will spur the innovation culture to overcome the challenges. The reliability and functionality of health care products originating from low-cost mindset will change the world healthcare delivery system. Hospitals can ensure availability, by cutting down the excessive comfort and service, safely reuse equipments, introduce low cost products without compromising quality, pay fixed salaries instead of fee-for-service model, increase scale of operation, build efficiency into purchase systems, family networks to ensure the customer touch points, and redesign the system around the need for low cost healthcare. In order to make the most from the prevailing necessity for sustainable and scalable solutions, the ten P's have been recommended.

The above 10 P's of frugal healthcare marketing will help entrepreneurs use a simple heuristic method to design their solutions for the poor.

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